

## COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH LANTERMAN-PETRIS-SHORT (LPS) ACT INITIAL AND RENEWAL AUTHORIZATION APPLICATION

(Please Print or Type)

			-allure to	complete a	ali items	may result in the application not being processed.)				
Training ID (found of the bulletin page	on upper right corne	r				Date of requested training (initial only)				
☐ Initial Application		Location Ch	ange Fro	om:	Train	ing or testing date previously				
☐ Renewal Applic		Location on	ungo i i	<b>21111</b>	completed (if applicable)					
	Number (non-county	employees s	supply th	e last fou		`				
Candidate's Name				Jo	b Title					
Resident Facility Staff	☐ Professiona Admitting P		_	Professio Admitting		f without				
Name of Agency, F	Program, or Hospital									
Work Address					City	Zip Code				
Work Telephone		Fax				E-mail				
List all other curre LPS Authorized (if	nt facilities at which									
	xperience as a licens	ed MH profes	ssional							
-										
Start Date with LA	CDMH (County/Contr	acted)				pleted your initial probationary period with inty/Contracted)?				
Current job descrip	tion of candidate wh	ich requires	that he/s		•	d (please check one):				
On-Site		•			<u>obile</u>					
	ounty Contracted Cli		е			tal Employee				
	Facility (inpatient)			L	<b>」Count</b>	ty Clinic/County Contracted Clinic Employee				
	I Facility (inpatient) N	עוו								
Field Based Service FSP Adult		FSP TAY [		older Adul	lt 🗆	FCCS Older Adult				
Credential [			LCSW	_	RN	☐ NP ☐ LVN (clinics only)				
	☐ PhD/PsyD ☐ M	D/DO [	Unlice	ensed Res	sident	☐ Other				
License No.						ion Date				
		all statemen	ts made			n are true and correct.				
Signature of Applic	cant:					nically in charge of Designated Facility or Agency				
					f applicant is clinically in charge then immediate supervisor must sign.)					
Date					rint Name					
				Signatui	re	Date				
	Office Use Onl	y: This section	on to be	complete	d after t	raining and examination.				
Test Score:	Pass:	Fail:	Test D	ate:		Designation Expiration:				
DMH Regional Med						Designation Expiration.				
RETURN INITIAL LPS TRAINING APPLICATION to:										
		_	IAL LPS	TRAINING	3 APPL	Date:				
		_				Date:				
	F	RETURN <u>I<b>NIT</b></u> Los Angeles Training a	County I and Quali	Departmer ty Improve	nt of Mer ement D	Date: ICATION to: ntal Health ivisions				
	695	RETURN <u>INIT</u> Los Angeles Training a S. Vermont A	County I and Quali venue, 1	Departmer ty Improve 5 <sup>th</sup> Floor, L	nt of Mer ement D os Ange	Date: ICATION to: ntal Health ivisions eles, CA 90005				
	695 <b>P</b>	RETURN INIT Los Angeles Training a S. Vermont A' hone No. (21	County I and Quali venue, 1 3) 251-6	Departmer ty Improve 5 <sup>th</sup> Floor, L <b>854</b> <u>Fax</u>	nt of Mer ement D os Ange (No. (21	Date: ICATION to: Intal Health Ivisions Icles, CA 90005 I3) 252-8776				
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## COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH ATTESTATION FOR LPS AUTHORIZED APPLICANTS

## **Certificate of Applicant:**

I attest that all statements made in this application are true and correct. I acknowledge that any false or incomplete statement given here or an omission of material fact will result in my disqualification. I further acknowledge that I have reviewed the <u>LACDMH "LPS Designation Guidelines and Process for Facilities within Los Angeles County," Fifth Edition (revised December 2010)</u>, and that I have read and understood this document, and will uphold all applicable legal, ethical, regulatory and reporting principles contained therein and in the standards of my professional license(s). Further, I will uphold basic ethical standards essential to the fulfillment of my responsibilities carried out in the application of my authority for involuntary detention, including but not limited to the following:

- Avoidance of circumstances where work based action may affect or appear to affect private financial interest or personal gain, financial or non-financial.
- Avoidance of any participation in a personal arrangement or business transaction
  which would generate potential or perceived conflict of interest or compromise my
  ability to provide treatment fairly and objectively.
- Avoidance of any circumstances that would hinder my ability to provide or refer to service that is of highest quality and effectiveness.
- Recognition and avoidance of any personal situation, habits or behaviors that might impair ability to provide competent care.
- Respect and protection of client confidential information, in accordance with applicable legal and regulatory standards.
- Performance of all duties in a manner that demonstrates an understanding of each client's personal dignity.
- Demonstration of highest standards of personal integrity in all work related activities carried out in the application of my authority for involuntary detention.

I acknowledge that, if I am given authority for involuntary detention, my failure to comply with the above principles and all laws, policies, by-laws or regulations related to involuntary detention, or with those portions of the LACDMH "LPS Designation Guidelines and Process for Facilities within Los Angeles County," Fifth Edition (revised December 2010) related to individuals (including any revisions thereafter adopted), will result in withdrawal of my involuntary detention authority. I acknowledge that involuntary detention authority may also be withdrawn without cause at any time by the LACDMH Director.

Signature of Applicant F	Print Name		Date
Credential, License No.	Expiration Date	3	
Designated Facility or Directly Operated Program	n or Contract Site Annroyee	d to Initiate I DS Invo	lunton, Holdo
Boorginated Facility of Birootly Operated Frogram	ii oi contiact Site Approvet	a to illitiate LF3 illvo	iuiitary noius
Address	City	State	Zip Code

202.3 Attachment I, pg. 2 Revised 10/26/11